cvhs
CENTRAL VIRGINIA HEALTH SERVICES

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WC: 02-60
WC: 17-310

May 8, 2018

Marlene H. Dortch, Secretary
Federal Communications Commission
445 12th street, SW
Room TW-A325
Washington, D.C. 20554

Re: Rural Health Care Program: Request to Promptly Approve Emergency Petition for Waiver of the Funding Cap Pending Conclusion of the Open Rulemaking

Dear Ms. Dortch,

Central Virginia Health Services, Inc. (CVHS) is writing to strongly urge the Commission to approve the Emergency Petition for Waiver of the Rural Health Care Program (RHCP) Funding Cap Pending Conclusion of the Open Rulemaking, which was recently filed by the Schools, Health & Libraries Broadband (SHLB) Coalition.

This letter begins with a summary of our request. It then provides background information on CVHS before outlining why it is why it is critically important to rural FQHCs such as us, and our medically-underserved patients, that the FCC approve the Emergency Petition promptly

SUMMARY OF REQUEST

CVHS strongly urges the FCC to promptly approve the Emergency Petition for Waiver of the RHCP Funding Cap Pending Conclusion of the Open Rulemaking, for the following reasons:

- The reductions in FY2017 RHCP payments to rural FQHCs are in direct contradiction to Congress' and HHS' long-standing efforts to expand EHRs and telehealth in rural communities.
- The reductions in FY2017 RHCP payments to rural FQHCs are significant, unexpected and largely-retroactive – and particularly difficult for small safety-net providers to absorb.
- Given the size of the FY2017 reductions – and the unpredictability of future payment amounts – many rural FQHCs are considering giving up activities that require broadband access, despite significant pressure from Congress and HHS to engage in these activities.
- Both the $400 million cap and FCC oversight of the RHCP are outdated, and rural safety-net providers should not be penalized while waiting for the FCC to completes its updates of both.

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- Given that rural providers and carriers are presently determining if -- and under what terms -- they will participate in the RHCP in FY18, the FCC should approve the emergency waiver promptly.

BACKGROUND ON CENTRAL VIRGINIA HEALTH SERVICES, INC. AND THE RURAL HEALTH CARE PROGRAM

Central Virginia Health Services, Inc. operates seventeen community health centers across the state of Virginia. We serve sixteen rural counties (Brunswick, Buckingham, Caroline, Charles City, Charlotte, Cumberland, Fluvanna, King and Queen, King William, Louisa, Prince Edward, Prince George, Richmond, Southern Albemarle, and Westmoreland) and four cities (Charlottesville, Fredericksburg, Hopewell, and Petersburg). In 2017, we saw 43,303 patients; 32% of our patients live below 100% of the Federal Poverty level and almost half live below 200% FPL. Roughly 35% are uninsured, and about 40% receive Medicare and Medicaid.

THE FCC SHOULD APPROVE THE EMERGENCY PETITION PROMPTLY

The following are five reasons why the FCC should act promptly to approve the Emergency Petition for Waiver of the Rural Health Care Program Funding Cap Pending Conclusion of the Open Rulemaking.

1. The reductions in FY2017 RHCP payments to rural FQHCs are in direct contradiction to Congress' and HHS' long-standing efforts to expand EHRs and telehealth in rural communities.

The significant, unexpected, and largely-retroactive reductions in FY17 RHCP payments (see discussion below) that the FCC announced in March 2018 are in direct contradiction to long-standing Federal policy aimed at making the U.S. health care system more accessible, efficient, and cost-effective.

Access to affordable, reliable broadband is increasingly important to all health care providers, and particularly for those located in rural and frontier areas. Beyond the standard needs for Internet access that are common across most industries (e.g., email, web searching and downloading), health care providers use broadband for two critical activities which are central to efforts to improve the accessibility, efficiency, and cost-effectiveness of the US health care system: Electronic Health Records (EHRs) and telehealth. As discussed below, for the past decade both Congress and the Federal Department of Health and Human Services (HHS) – under both President Obama and President Trump – have strongly encouraged, and sometimes required, health care providers to engage in both of these activities:

- **Electronic Health Records**: Starting in 2009, Congress directed the Federal Centers for Medicare and Medicaid Services (CMS) to provide incentive payments to health care providers to implement and demonstrate "meaningful use" of Electronic Health Records (EHRs.) As of

February 2018, payments under this program totaled $38 billion[1]. More recently, CMS has begun switching from incentivizing providers to develop and use EHRs, to penalizing those who do not.

In December 2016, as part of the 21st Century Cures Act, Congress enacted a number of provisions directly impacting health care technology. The provisions involving EHRs largely involved accessibility (patients' ability to access their own records easily and securely) and interoperability (the capacity for health information to be seamlessly and securely shared across providers.) As a result, a wide range of initiatives are currently emanating from the White House, the HHS Office of the National Coordinator for Health IT (ONC), and CMS to advance these two goals.

- **Using telehealth to improve access, reduce costs, and enhance quality:**

  Key players across the health care system – including Congress, HHS, and the White House – are increasingly pushing for the expanded use of telehealth as a means to increase access to health care, reduce costs, improve quality, and improve patient outcomes. As a result, they are publicly supportive of efforts to reduce barriers to providers' use of telehealth – particularly for rural providers.

  For example, in February 2018, during his Congressional confirmation hearings, HHS Secretary Alex Azar stated:

  > "I am a big supporter of telehealth and how we can harness that, especially for underserved areas like our rural communities.... So I would love to work with you on that as I go back and we plow through and identify those barriers to see where we might make changes."

  In response, Congressman Morgan Griffith (R-VA) stated: "I don't think it's a partisan issue. I think you'd find support on both sides of the aisle to change laws that are keeping you all from doing things that we all want you to do... in relation to telehealth."

  In particular, the current Administration has hailed health centers as national leaders in the use of telehealth. In his March 2018 keynote address at the annual FQHC meeting, Secretary Azar stated: **"Telehealth is one area where health centers have taken the lead**, and where we aim to keep payment policies up to date with the innovations we're seeing." *(emphasis added)*[2]

By imposing large, unexpected, and largely-retroactive reductions in RHCP payments, the FCC is undermining the ability of rural FQHCs to engage in those activities which Congress and the Administrations have been strongly encouraging and praising them for doing – thereby creating exactly the sort of barrier that Secretary Azar and Congress are actively seeking to remove.

2. **The reductions in FY2017 RHCP payments to rural FQHCs are significant, unexpected and largely-retroactive – and particularly difficult for small safety-net providers to absorb.**
   The FCC's announcement of 15% - 25% reductions in FY17 payment levels over eight months into the Funding Year has been a significant and unexpected financial blow to many rural FQHCs.

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[1] HHS' February 2018 EHR Incentive Program Payment Summary – available at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/February2018_SummaryReport.pdf

[2] https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-to-the-national-association-of-community-health-centers.html

- Unexpected: In contrast, the FY17 payment reductions were both unpredictable and unexpected. As discussed in the Emergency Petition, gross demand for RHCP payments for FY17 was approximately equal to gross demand in FY16, and the "denial rate" of applications has been fairly stable throughout the RHCP's history. As a result, assuming a $400 million cap, it was reasonable for RHCP recipients to assume that the proration amount for FY17 would be similar to the 7.5% amount for FY2016. In addition, the FCC's decision to add approximately $30 million in additional funding suggested that the FY17 proration amount – if any – would be lower than in FY16. Given this history, the actual FY17 amounts – 15% and 25% – were unpredictable and very unexpected.

  As you are aware, Section 47 U.S.C. § 254(b)(5) requires that "There should be specific, ***predictable*** and sufficient Federal and State mechanisms to preserve and advance universal service." *(emphasis added)* Furthermore, the FCC emphasized the importance of predictable funding in its original order on the Universal Service Support (CC Docket No. 96-45, adopted May 7, 1997), which referenced predictability over 50 times. Thus, these large and unpredictable reductions are inconsistent with both to the statute and the FCC's stated priorities for the Universal Service program.

- Largely retroactive: As discussed in the Emergency Petition, the FY17 cuts are largely retroactive because they were not announced by USAC until more than eight months after the start of the funding year (and the deadline for applications) -- much later than was reasonably expected.

- Particularly difficult for small safety-net providers to absorb: As discussed above, FQHCs target underserved populations and provide a full range of services to every patient, regardless of their ability to pay. As a result of this mission, and the fact that nearly three-quarters of our patients have incomes below the Federal Poverty Level, FQHCs generally run on very small margins – often around 1 percent. For this reason, large and unexpected reductions in critical funding sources – such as the RHCP subsidies – are very destabilizing, and can threaten the FQHC's overall financial stability.

For these reasons, rural health centers across the country are currently scrambling to determine how to absorb these large, unexpected reductions while minimizing the impact on patient care.

3. **Given the size of the FY2017 reductions – and the unpredictability of future payment amounts – many rural FQHCs are considering giving up activities that require broadband access, despite significant pressure from Congress and HHS to engage in these activities.**
Given their experience with FY17 RHCP payments, rural FQHCs are no longer confident that they can afford to maintain their broadband connections. Many FQHCs are finding that they must use the funds they had budgeted for FY18 broadband to pay the unexpected, retroactive charges they now owe for FY17 – leaving nothing available for the coming year. They also are very hesitant to commit to contracts with broadband carriers for FY18 when they are unable to predict what their actual costs will be.

Due to this uncertainty, combined with their slim operating margins, some rural FQHCs are concluding that they must dramatically scale back their use of technology in order to ensure their financial stability. This may include switching from EHRs back to paper records, and stopping all telehealth activities. As one health center CEO stated recently "Paper records may be old-fashioned

and inefficient, but at least we know what they'll cost us. And telehealth is great for our patients, but if unexpected bills could force us to shut down our whole operation, it's not worth the risk."

As stated above, these sorts of outcomes would be in direct contradiction to long-term efforts of Congress and both the Obama and Trump Administrations to increase access, efficiency, and cost-effectiveness in the U.S. health care system. Thus, the FCC's recent actions are undermining at least a decade of Federal health policy.

4. **Both the $400 million cap and FCC oversight of the RCP are outdated, and rural safety-net providers should not be penalized while waiting for the FCC to complete its update of both.**

As explained in the Emergency Petition, the current $400 million cap was established in 1998, based on estimates about the number of eligible providers and the type of connectivity available at that time. Clearly, this estimate is significantly outdated, not only because of the major advances in technology but also due to major expansion in both the number and type of eligible providers, including but not limited to Skilled Nursing Facilities and urban members of urban-rural consortia.

Also, despite the RHCP being 20 years old, the FCC has yet to implement basic program integrity controls, such as limitations on gifts that consultants may provide, and review of extremely high (i.e., outlier) payment requests. We sincerely appreciate the proposed rulemaking that the FCC published last year addressing these and related issues, and NAHC submitted detailed comments supporting increased oversight. However, until such controls are in place, it is inappropriate to penalize rural safety-net providers such as FQHCs due to the FCC's failure to update its oversight of the program in a timely manner.

Finally, as discussed in the comments submitted by the National Association of Community Health Centers regarding Paragraph 19 of WC Docket No. 17-310, if payment reductions are necessary, a prioritization approach should be applied. Specifically, priority should be being given to those providers who are clearly eligible under a plain reading of the statute – namely, "public or non-profit" providers who actually "serve(s) persons who reside in rural areas". While we recognize that it is likely too late to apply a prioritization approach for FY17 funding, we strongly encourage the FCC to adopt such an approach if reductions become necessary in future years.

5. **Given that rural providers and carriers are presently determining if -- and under what terms -- they will participate in the RHCP in FY18, the FCC should approve the emergency waiver promptly.**

Since contracts between RHCP providers and carriers are based on the RHCP funding year (July – June), providers and carriers are currently determining under what terms they will participate in the program in FY18. As stated above, many rural FQHCs are seriously considering withdrawing from the program entirely rather than risk large, unpredictable bills such as they received in FY17. FQHCs are also concerned that carriers will reconsider their participation in the program, due to concerns about the stability of long-term funding. For these reasons, it is urgent that the FCC act quickly to approve the emergency waiver, before providers and carriers being withdrawing from the program for FY18.

Thank you for your attention to this request, and for your efforts to increase access to care for medically underserved patients in rural areas. Please feel free to contact me directly if you would like additional information.

Sincerely,

Charles Allbaugh, CPA
Chief Financial Officer